

# PL PHYSICIANS

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## HIPAA NOTICE OF PRIVACY PRACTICE

Would you like to authorize anyone other than yourself to receive your health information?

If so, who: \_\_\_\_\_

Relationship: \_\_\_\_\_

If so, who: \_\_\_\_\_

Relationship: \_\_\_\_\_

If so, who: \_\_\_\_\_

Relationship: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

**I have received or been offered a copy of the Notice of Privacy Practices for PL Physicians.**

**Name of Patient(print):** \_\_\_\_\_

**Signature of Patient or Responsible Party:** \_\_\_\_\_

**Date:** \_\_\_\_\_